COUNTY OF SAN BERNARDINO	No. 14-1.36	Issue 05/2004
	By Rosaria Bulgarella	Page 1 of 4
		Effective 04/2003
DEPARTMENT BEHAVIORAL HEALTH	Approved	
SUBJECT **CLIENT ACCESS AND AMENDMENT OF MEDICAL RECORD**	Carol Hughes, Assistant Director	

I. PURPOSE

The purpose of this policy is to provide procedures for responding to requests by San Bernardino County Department of Behavioral Health clients to inspect, copy and amend their medical record.

II. POLICY

The medical record containing protected health information (PHI) regarding a San Bernardino County client is the property of the San Bernardino County Department of Behavioral Health.

Clients have the right to inspect and obtain a copy of their medical record with certain legal limitations upon written request.

Clients have the right to request an amendment to their medical record if they believe an item or statement is incomplete or incorrect.

San Bernardino County Department of Behavioral Heath has the right to deny a client's request to access or amend his/her medical record.

Under certain circumstances, a Licensed Practitioner of the Healing Arts (LPHA - psychiatrist, psychologist, licensed social worker or licensed marriage family therapist) may prepare a summary of the medical record rather than allowing the client access to the medical record.

III. PROCEDURES FOR ACCESS OR COPY

Client's Right to Access His/Her Medical Record. An adult client, a minor client who has the right to consent to treatment, or a client's legal representative may be entitled to inspect or copy the client's record upon presenting a written request to the Medical Records Department and payment of a reasonable cost for making the record available.

The minor is entitled to inspect only those records for which the minor is lawfully authorized to consent.

If the records are for the purpose of supporting an appeal for government benefits such as Supplement Security Income (SSI), Social Security Disability, or Medi-Cal, the consumer is entitled to have the records provided at no cost. The consumer must provide proof that the records are being requested for an appeal.

The client may make a request to access his medical record at any clinic or at the Medical Record Department.

Summary in Lieu of Actual Record. The Department may choose to prepare a summary of the client's record instead of allowing the client to inspect and copy the record.

1. The client must agree to the summary before it is prepared.

2. The service provider/staff should confer with the client to clarify the purpose and goal in obtaining his/her record.

3. The summary must be prepared within five (5) working days and include the following items as appropriate:

    a. The chief complaint

    b. The diagnosis

    c. Client plan including medications prescribed

    d. Client's progress

    e. Client's problems, including any significant ongoing problems.

Accessing or copying of the original record.

1 Upon request, client will be given a packet consisting of the pamphlet, Release of Information: Patient's Right of Access to His/Her Own Medical Record (Attachment 1) and the form, Request for Access to Protected Health Information (Attachment 2).

2. Client will be instructed to fill the form (Attachment 2) out completely and send it or hand carry it to the Medical Record Department.

3. Medical Records will have **five (5) working days** to respond to the request when an appropriately completed form (Attachment 2) is received.

4. If an extension is necessary, the consumer will be notified immediately of an extension of 30 days and the reason for the extension.

5. Medical Records will record the date of receipt of the completed request form in a tickler file for tracking to ensure that the following takes place within the specified time limits:

    a. Medical Records will date and send the following packet to the LPHA who will review the case:

        i. The original Request for Access to Protected Health Information form (Attachment 2)

        ii. The Internal Tracking of Request for Access to PHI form (Attachment 3)

        iii. Client medical record.

6. The LPHA will note the timeline to return the form (Attachment 3), determine whether to allow access to the medical record and return the completed form to the Medical Records Department in a timely manner.

7. Medical Records will complete the Response to Access Protected Health Information form (Attachment 4) and mail it to the client within the specified timeline.

8. **APPROVALS:** If approved, LPHA will complete Part I (Approved Access Section) of Attachment 3. Medical Records will complete Part II. The record will be made available for inspection during normal business hours.

9. **DENIALS:** If denied, LPHA will complete Part III (Denied Access Section) of Attachment 3. When the LPHA determines that there is substantial risk of significant adverse or detrimental consequences to the client or another person if access to the medical records is granted, the LPHA must include documentation of the decision to refuse inspection or copying of the mental health record in the client's chart. The note must give the date of the request and a description of the specific adverse or detrimental consequences that the client or another may experience if access were permitted.

10. **APPEAL OF DENIAL:** If the client submits a written request to review the decision of denial, Medical Records will repeat Steps 4 through 7 by sending the packet, including the written request for appeal, to an independent LPHA. The client will be notified of the decision within 30 days of receipt of the written request.

IV. PROCEDURE FOR AMENDING PHI

A client who believes any part of his/her medical record is incomplete or inaccurate may make a written request to amend his/her record. To do so, the client must state in writing that he/she wishes the amendment to be made part of the medical record.

1. The client may make a request to amend at any DBH clinic or at the Medical Records Department. The client will be given the *Request to Amend Protected Health Information (PHI)* form (Attachment 5).

2. The client will be instructed to return the form to the Medical Records Department.

3. Medical Records will send a packet containing the form (Attachment 5), the medical record and the Response to Request to Amend PHI (Attachment 6) to an LPHA who will determine if the amendment will be accepted.

4. The LPHA will review the medical record for a decision, fill out Attachment 6 and return the packet to Medical Records.

5. **ACCEPTANCE**: If approved, the amendment will be placed in the medical record and will be included whenever a copy is made of the alleged incomplete or incorrect part of the record to any third party. If the amendment contains any defamatory or otherwise unlawful language, the Department is not subject to any liability in any criminal, administrative, or other proceeding.

6. **DENIAL**: A client's request for amendment may be denied if it is determined that:

    a. The information in the medical record was not created by DBH
    b. The information is not part of the designated record set
    c. The record is accurate and complete

    Medical Records will notify the client in writing of the denial in a timely manner (30 days) by sending the client a copy of Attachment 6. Attachment 6 gives the basis for the denial, instructions on how the individual may submit comments regarding the denial and information about complaint procedure and instructions on how to file a complaint.

San Bernardino County Department of Behavioral Health

RELEASE OF INFORMATION: PATIENT'S RIGHT OF ACCESS TO HIS/HER OWN MEDICAL RECORD

California Health and Safety Code §123100 and HIPAA federal regulations 45C.F.R. §164.524 guarantees patients access to their own medical record information, with certain limitations. Federal regulations and patient access concerning drug and alcohol abuse records are covered by 42C.F.R. & 2.1 *et seq*. Access can be *denied* under specific circumstances specified in the law and under the HIPAA regulations. Under some circumstances the denial of access can be reviewed.

WHAT RECORDS ARE AVAILABLE TO PATIENT ACCESS?

Access must be provided to the designated record set in the possession of a licensed health care provider listed in the law. This includes all licensed hospitals, skilled nursing homes, clinics, licensed physicians, dentists, podiatrists, chiropractors, clinical social workers, and marriage, family and child counselors.

ARE THERE LIMITATIONS?

The law describes certain types of information which are not considered to be a part of the medical record, e.g., any aggregate information about several patients, information regarding any other patient, certain information which may have been provided in confidence by someone other than the patient, or any other material that would not normally be considered a part of the medical record. Federal regulations place some additional limitations on access to substance abuse records.

WHO CAN HAVE ACCESS TO MY MEDICAL RECORD?

Adult patients can have access to their own records, unless the patient is under a conservatorship of the person or has an "attorney-in-fact" (an agent appointed under the durable power of attorney law to make health care decisions in the event of incompetency). In that case, the conservator or attorney-in-fact has the right of access as the patient's representative. If access is requested by either the conservator or the attorney-in-fact, the provider must see the legal documents confirming such status.

RECORDS OF DECEASED PATIENTS

The definition of "personal representative" in the law includes the beneficiary or personal representative of a deceased patient. Therefore, a deceased patient's beneficiary or personal representative will have the same right of access as the patient would have had if he or she were still living. The beneficiary is anyone who will inherit from the patient either by will or intestate. The personal representative is either the administrator of the patient's estate or the executor under the patient's will. The law does not give any other person the right to obtain access to a deceased patient's records.

CAN I BE DENIED ACCESS TO MY RECORDS?

Yes. The law provides that the health care provider can deny access to the minor's records requested by the parent or guardian if it is believed that disclosure will have a detrimental effect on the provider's treatment relationship with the minor patient. Access can also be denied if the provider believes that disclosure to the parent or guardian may have an adverse effect on the minor patient's safety or psychological well being. Denial of access is mandatory when the parent or guardian seeks access to the record of a minor patient if the minor has the right to

consent to treatment. The provider will usually notify the parent or guardian if access is being denied.

Access can also be denied to the psychiatric patient if the provider believes that such disclosure may have a significant adverse consequence for the patient. In the event of this type of denial, the patient may request a review of the denial by a physician, licensed social worker, or licensed clinical psychologist appointed by the provider that did not participate in the original decision to deny. Moreover, the patient may request a summary, instead of the actual medical record.

Substance abuse records governed by federal regulation are not subject to California *patient access law*. Federal regulations governing disclosure of information from alcohol and drug abuse records [42 C.F.R. & 2.1 *et seq.*] do not give the patient an automatic right to inspect or obtain copies of medical records if the provider determines that such disclosure will harm the patient or the program's overall provision of services to the community.

WHAT TYPE OF ACCESS MAY I REQUEST?

You may ask to inspect the original records or to receive copies of all or part of the record.

If you request inspection and find at the time of inspection that you would also like copies, they may be requested at that time, but this constitutes a new request.

You may also request a summary of the information requested in lieu of either inspection or copies.

WHAT IS MEANT BY "INSPECTION" AND "SUMMARY"?

Inspection means that you go to the hospital or office to review the actual original medical record. A summary is a narrative account of the requested information, but not a copy of the actual record.

We will arrange with you a convenient time and place to inspect or obtain copies of the protected health information you are requesting, or we will mail copies of the PHI at your request.

HOW DO I REQUEST ACCESS?

Requests for access must be in writing. *

Your written request should have the following:

Full name of patient, including maiden, and any other names that may have been used

Birthday (and social security number if available)

The type of access requested

In requesting copies, you should indicate the following:

What parts of the medical record you want

(You should request only those parts that have to do with the need for the access.)

* Please complete the form "Request to Access or Copy Protected Health Information (PHI)" (attachment 2) of this handout as your written request for access. You must complete this form in full or it will be returned to you to do so.

WHAT WILL IT COST ME?

The law recognizes that health care providers will incur some expense in providing access and permits recovery of these costs, including a charge for copying. If copies are requested, there will be an additional charge. Since most records are lengthy, you may want to consider just what your actual needs are and limit your request for copies to those specific items, rather than requesting the entire record. The law also permits the provider to charge for the expense involved in preparing the summary alternative. You may ask for a price list from the Medical Records Department, phone number: (909) 421-9350.

DO I HAVE TO PAY IN ADVANCE?

YES. The law makes access conditional upon the prepayment of allowable charges, and you will be expected to pay before inspection or copying. If you have requested copies, the provider will send you a statement of expected charges before making the copies so that you will have the opportunity to change your request if the charge is greater than anticipated.

IF MY REQUEST IS APPROVED, HOW SOON WILL I HAVE ACCESS?

California law specifies that inspection must be permitted within five (5) working days and copies must be available within fifteen (15) days after a **VALID WRITTEN REQUEST IS RECEIVED**. If you request the summary alternative, it must be available within ten (10) working days, but this can be extended to thirty (30) calendar days if the record is lengthy or if the patient has been discharged from the facility within the previous ten (10) calendar days. If an extension will be needed, you will be notified.

A REQUEST IS NOT CONSIDERED VALID UNTIL THE INFORMATION FURNISHED IS ADEQUATE TO IDENTIFY THE RECORD PROPERLY AND PAYMENT IS MADE FOR REQUESTED COPIES.

ARE THERE OTHER WAYS I CAN OBTAIN INFORMATION FROM MY RECORD?

Yes. Health care facilities ordinarily furnish information necessary to continue your care when it is requested by another physician or hospital. If your insurance company, school, employer or other third party needs information from your record, it is usually better to let them request it directly, as they can be more precise about what they need. Any charges for information furnished in this way is usually paid by the third party that has requested the information. Such requests will require a valid written authorization from you to release the information. This authorization may be obtained from the Medical Record Section or the clinic that you attend.

SAN BERNARDINO COUNTY DEPARTMENT OF BEHAVIORAL HEALTH

Request to Access or Copy Protected Health Information (PHI)

(RETURN COMPLETED FORM TO MEDICAL RECORDS DEPT, 850 E FOOTHILL BLVD, RIALTO, CA 92376)

REQUESTOR INFORMATION

Your name _____

Your mailing address

_____

Your phone number Daytime _____ Evening _____

If you are not the Consumer, your relationship to the Consumer* _____

***Please furnish a copy of papers of legal appointment, court order or notarized will with this request.**

CLIENT INFORMATION

Client name (if different) _____

Client's maiden name (if applicable) _____

Client Birthdate _____ Client chart No _____

ACCESS/COPY REQUEST INFORMATION

Do you wish to ☐ access (read and review) the PHI ☐ receive a copy of the PHI ☐ receive a summary

Describe the information you want to access

☐ Diagnosis ☐ Prognosis ☐ Medication ☐ Side effects of Meds RX

☐ Dates of Treatment ☐ Progress Notes

☐ Evaluation/Assessment ☐ Lab Reports ☐ Medical History-Evaluations

☐ OTHER Please specify "other" information and the specific purpose for which it is needed _____

_____

_____

Date(s) of information you want access (e g., date of office visit, treatment, or other health care services)

From. _____ To: _____

- We will inform you of the cost of your copy before we make the copy and verify that you agree to pay for the copy How would you like us to inform you (pick one) ☐ phone ☐ letter
- We will require you to pay for your copy before you receive it
- We will notify you in writing within 5 working days of your request (30 days if the PHI is not maintained or accessible on-site) if and when your PHI will be available for access, where you will need to come to access your PHI to read and review it, or where to come to pay for and pick up your copy
- In exceptional circumstances, we will notify you within 30 days if we need one additional period of 30 days to respond to your request
- In specific circumstances, we may deny access to your PHI, or to a portion of your PHI.
- If we deny access, we will return this form to you with our written reasons for denying access, and explain your review rights, if they apply
-

_____ _____

Printed Name of ☐ consumer or ☐ legal representative Date

_____ _____

Signature of ☐ consumer or ☐ legal representative Date

INTERNAL TRACKING OF REQUEST FOR ACCESS TO PHI

DETERMINATION OF APPROVAL OR DENIAL OF ACCESS

This form must be returned to the Medical Records Department with your determination by (date)_____

This is to inform you that we have received a request for access to the PHI of the client named on this form.

This request was received from:
( ) Patient
( ) Parent, guardian, or conservator

The type of access request is:
( ) Inspection
( ) Copies
( ) Summary

If access is approved, please complete PART II of this form, signing and dating as appropriate. In certain circumstances, access can be denied. If access is denied, please complete PART IV, including reason for denial, your signature and date of decision

The law states inspection must be permitted within 5 working days after receipt of the request. Copies must be transmitted within 15 calendar days or if a summary is requested within 10 working days (can be extended to 30 days if, for example, the record is in storage).

After making your determination, **A NOTATION MUST BE ENTERED IN THE MEDICAL RECORD** explaining

a. The reason you denied the requester to review/receive copies of the medical record AND a description of the specific adverse or detrimental consequences to the patient or professional relationship to patient, if access was allowed or

b What your professional relationship to the patient is if access was allowed

PART I - APPROVED ACCESS

(Completed by Licensed health care professional to complete)

Access to PHI is approved to provide._____
(Specify copies, summary and or inspection)

Date_____ _____ _____ _____
Signature Printed name License/title

PART II – (COMPLETED BY MEDICAL RECORDS DEPARTMENT)

Check the box(es) below to indicate action taken on request for access to PHI

☐ How was the identity of the individual verified?_____

☐ Date the individual was informed of acceptance of access request and any cost to client._____ $ _____

☐ Date of referral to another organization/location to obtain the information because the information requested is not part of the Designated Records Set. _____

☐ Date the individual was sent notice that access or denial of access will not be determined within the time limit and anticipated date of completion of request.
_____

WHAT THE INDIVIDUAL ACCESSED:

- ☐ Diagnosis
- ☐ Medication
- ☐ Prognosis
- ☐ Evaluation/Assessment
- ☐ Lab Reports
- ☐ Medical History – Evaluations
- ☐ Dates of treatment
- ☐ Side Effects of Medication Treatment
- ☐ Other: _____

specify "other" information

HOW DID THE INDIVIDUAL RECEIVE THE INFORMATION:

- ☐ Orally in person in the office
- ☐ Reviewed in person
- ☐ Orally over the telephone
- ☐ Picked up in person
- ☐ Mailed

☐ What PHI did the individual access. (List all documents released from the individual's file)

Date of Access_____ Location of Access_____

PART III - DENIED ACCESS

(*Completed by licensed health care professional to complete; check box(es) that apply*)

Access to PHI was denied because it is EXEMPT FROM ACCESS for the following reasons:

- ☐ The information is not in the designated record set.
- ☐ Information was compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding.

Access to PHI was denied under the following NON-REVIEWABLE GROUNDS:

- ☐ Information is from tests by clinical laboratories that state laws allow only for release to the persons who orders the test.
- ☐ Information is requested by an inmate of a correctional institution and such information would jeopardize the health, safety, security, custody, or rehabilitation of the individual or other inmates or the safety of other persons at the institution or those individuals responsible for transporting the inmate.
- ☐ Information is for which the individual has agreed to denial of access when consenting to participate in research for the course of the research project.
- ☐ Information has been requested under the Freedom of Information Act
- ☐ Information requested was obtained from someone other than a health care provider under the promise of confidentiality and access would likely reveal the source of the information.

Access to PHI was denied under the following **REVIEWABLE GROUNDS:**

- ☐ Access to the PHI is likely to endanger the life or physical safety of the individual or another person
- ☐ The PHI refers to another person and a licensed health care professional has determined that access is reasonably likely to cause substantial harm to such other person
- ☐ The information is requested by the personal representative of the individual and a licensed health care professional has determined that provision of access is reasonably likely to cause substantial harm to the individual or another person.

_____ Signature of health care professional

_____ Printed name

_____ Title

_____ Date

- ☐ All access was denied
- ☐ Partial access was denied

SAN BERNARDINO COUNTY DEPARTMENT OF BEHAVIORAL HEALTH

Response to Request to Access or Copy Protected Health Information (PHI)

Date: **Your request to ☐ access ☐ copy ☐ both access and copy your PHI is:**

☐ **Approved**

☐ Your PHI will be available for access on _____ (date) and will be available until _____ (date)

Your PHI will be held for you in the Medical Records Department at **850 E. FOOTHILL BLVD, RIALTO, CA 92376.**

☐ The copy of your PHI will cost $ _____ Plus $ _____ in postage if we mail your copy to you. If you wish for us to mail it to you, please send us a check or money order for $_____ to the address above and we will mail you your copy. You may save the postage cost by picking up your copy between the dates shown above at the address you selected Please bring a check or money order for $ _____ with you at that time to receive your copy

☐ **Denied**

☐ Your request was denied because the Personal Health Information (PHI) that you requested to access includes the following type (s) of information that are exempt form the access rules·

☐ Psychotherapy notes;

☐ Information that was reasonably compiled in anticipation of, or use in, civil, criminal or administrative legal actions or proceedings,

☐ You were a participant in a research study and previously agreed to a denial of access to the request PHI when you consented to participate in the study, and the study is still continuing Your ability to access this PHI will be restored upon completion of the research, or

☐ The PHI was obtained from another person (other than a health care provider) under a promise of confidentiality and granting access would likely reveal the source's identity

The above reasons for Access denial, under the regulations, are NOT eligible for additional review or appeal We will grant you access to the parts of your PHI that do not contain the restricted information described above. You may access the parts of your PHI that we can share with you at the address above between the dates listed above, during normal working hours

☐ Your request was denied because the PHI that you requested to access was reviewed by our designated licensed practitioner of the healing arts (LPHA), who determined that circumstances exist that permit denial of access You may appeal this decision by requesting another review by an independent LPHA in writing.

I. THIS SECTION FOR OFFICE USE ONLY

Date request received· _____ Extension required: ☐ No ☐ Yes

If yes, reason given for extension: _____

Consumer notified in writing of extension on this date: _____

Name of staff member (LPHA) processing request (Print): _____

Signature of staff member (LPHA) processing request: _____

Date Access or Copy Approved· _____

If your access request was denied for the last reason, you may seek review of the decision by submitting a written request for review to the Medical Records. The reviewing official will provide you a written answer within 30 days If you believe that we have not followed our information privacy policies or the federal regulations, you may file a complaint by contacting.

pt of Behavioral Health, Compliance Unit 700 E Gilbert Street, Bld 2 San Bernardino, CA 92415 (909) 387-7028	Jim Pesta, Ethics Resource Officer 504 N Mt View Ave San Bernardino, CA 92415 (909) 381-7960	Office of Civil Rights, Att Regional Manager 50 United Nations Plaza, Room 322 San Francisco, CA 94102

SAN BERNARDINO COUNTY DEPARTMENT OF BEHAVIORAL HEALTH
Request to Amend Protected Health Information (PHI)

REQUESTOR INFORMATION

Your name: _____

Your mailing address: _____

Your phone number: Daytime: _____ Evening. _____

If you are not the Client, your relationship to the Client: _____

CLIENT INFORMATION

Client name (if different): _____

Client birth date: _____ Client No. _____

AMENDMENT REQUEST INFORMATION

Describe the information you want to amend due to inaccuracy or incompleteness (e.g., lab test results, physician notes).

_____

Date(s) of information you want amended (e.g., date of office visit, treatment, or other health care services).

_____

What is the reason for this request? _____

_____

How is the current information inaccurate or incomplete? _____

_____

What should the entry say to be more accurate of complete? _____

_____

Do you know of anyone who may have received or relied on the information you want to amend (such as your family doctor, pharmacist, health plan, or other health care provider? ☐ Yes ☐ No
If yes, please give the name(s) and address(es) of the organization(s) or individual(s):

_____

_____

_____

Do you specifically authorize us to notify the person(s) listed above, and any other persons or entities with whom we may have shared the information to be amended, of any amendment that is made to your health information as a result of this request? ☐ Yes ☐ No

_____ _____
Signature of consumer/legal representative Date

You will receive a written response from us within 60 calendar days of our receipt of your request. In a very few circumstances, we may need an additional 30 days to respond to a request for amendment beyond the 60 day period. If that happens in your case, we will send you a written notice before the 60 days expire to inform you that we will need the additional 30 days to respond. If your request for amendment is denied, you will receive a written reason for the denial and we will explain your rights to have the denial decision reviewed and/or your right to submit a written statement of disagreement that can be included in future disclosures of the un-amended information.

SAN BERNARDINO COUNTY DEPARTMENT OF BEHAVIORAL HEALTH

Response to Request to Amend PHI

request to amend your PHI is
ccepted

If accepted, date amendment is included in the health information record _____

Date that authorized persons were notified of record amendment _____

☐ Denied

If denied, your request was denied for the following reason(s)

☐ The PHI that you requested us to amend was not created by our agency and the agency or individual who created the PHI must make the decision to amend Please contact the agency or individual that created the PHI that you wish to amend about your desire to amend the PHI.

☐ The PHI that you requested us to amend is not part of the patient's designated record set In accordance with the federal regulations, only information that is part of the designated record set is subject to amendment.

☐ The PHI that you requested us to amend is accurate and complete.

Staff Comments _____

_____

Your Rights Upon Receipt of a Denial

If your request for amendment was denied, you may exercise the following rights·

☐ You may submit a written statement of disagreement (not to exceed 1-page in length) that will be included with the unchanged health information in any future disclosure of the information. If you submit such a statement, we have the right under the regulations to prepare a rebuttal answer to your statement and we would include our answer along with your statement in any future disclosures of the unchanged information. We are required to provide you a copy of our rebuttal answer if we decide to create one

☐ If you decide to not submit a statement of disagreement, you may, by checking this box, direct us to include your amendment request and this denial response with the unchanged PHI in any future disclosures or use of this information.

☐ If you believe that we have not followed our information privacy policies or the federal regulations, you may file a complaint by contacting the San Bernardino County Department of Behavioral Health, 700 E. Gilbert Street, San Bernardino, CA 92415, phone # (909) 387-7028, or you may contact the Office for Civil Rights, Attention Regional Manager, 50 United Nations Plaza, Room 322, San Francisco, CA 94102

Please return a copy of this form to us at the site selected on the front page of this form. Notify us of which of the above rights you wish to exercise by checking the box, submitting a written complaint or statement (if applicable) and signing this form below. If you do not wish to exercise any of these rights, retain this form for your records.

_____ _____

Printed Name of ☐ consumer or ☐ legal representative Date

_____ _____

Signature of ☐ consumer or ☐ legal representative Date

THIS SECTION FOR SAN BERNARDINO COUNTY DEPARTMENT OF BEHAVIORAL HEALTH USE ONLY

Written statement received? ☐ **Yes** ☐ **No** If yes, date received. _____

Rebuttal to be included? ☐ **Yes** ☐ **No** If yes, date rebuttal mailed to requester: _____

Date request received _____ Decided within 60 days of request? ☐ Yes ☐ No

Extension required ☐ No ☐ Yes If yes, reason give for extension: _____

Consumer notified in writing of extension on this date: _____

Name of staff member (LPHA) processing request (print). _____

Signature of staff member (LPHA) processing request: _____